BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Lawrence L. McAlpine, M.D. License # C22630 Respondent.	)	D-3980

DECISION

The attached Stipulation is hereby adopted by the Division of Medical Quality of the Board of Medical Quality Assurance as its Decision in the above-entitled matter.

This Decision shall become effective on July 30, 1990.

IT IS SO ORDERED June 28, 1990.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

Theresa Claassen

THERESA CLAASSEN, Secretary-Treasurer

JOHN K. VAN DE KAMP, Attorney General
of the State of California
LINDA J. VOGEL,
Deputy Attorney General
3580 Wilshire Boulevard
Los Angeles, California 90010
Telephone: (213) 736-3512

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LAWRENCE L. MC ALPINE, M.D. 650 HOBSON WAY OXNARD, CALIFORNIA 93030 Physician's and Surgeon's Certificate Number C22630 Respondent.	NO. D-3980 STIPULATION FOR SETTLEMENT AND DECISION

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled matter as follows:

1. At the time of executing and filing the accusation and notice of amendment in the accusation in the above matter, complainant, Kenneth Wagstaff was the Executive Director of the Board of Medical Quality Assurance (hereinafter the "board") and performed such acts solely in his official capacity as such.

2. Kenneth Wagstaff is represented herein by John K. Van De Kamp, Attorney General of the State of California, by Linda J. Vogel, Deputy Attorney General.

3. Lawrence L. Mc Alpine, M.D. (hereinafter "respondent ") is represented herein by Joseph D. O'Neill, attorney at law. Respondent has retained Joseph D. O'Neill, attorney at law, as his attorney in regard to the administrative action herein, and respondent has counseled with Joseph D. O'Neill concerning the effect of this stipulation, which respondent has carefully read and which he fully understands.

4. Respondent was duly served with and has read the accusation and notice of amendment presently on file and pending in case number D-3980 before the Board of Medical Quality Assurance.

5. Respondent understands the nature of the charges alleged in the above mentioned accusation, and respondent understands that said charges and allegations would constitute cause for imposing discipline upon respondent's physician's and surgeon's certificate heretofore issued by the Board of Medical Quality Assurance.

6. Respondent and his counsel are aware of each of respondent's rights, including the right to a hearing on the charges and allegations; respondent's right to confront and cross-examine witnesses who would testify against him; respondent's right to present evidence in his favor and to call witnesses in his behalf, and/or to so testify himself; respondent's right to contest the charges and allegations and any and other rights which may be accorded to him pursuant to the California Administrative Procedure Act (Government Code § 11500 et seq.); his right to reconsideration, appeal to superior court,

and to any other or further appeal; respondent understands that in signing this stipulation rather than contesting the accusation, he is enabling the Board of Medical Quality Assurance to discipline his physician's and surgeon's certificate upon this stipulation, without further process.

7. Respondent freely and voluntarily waives his rights to a hearing, reconsideration, appeal, and any and all other rights set forth in the California Administrative Procedure Act and the California Code of Civil Procedure. Respondent, rather than contesting the charges in accusation number D-3980 at a formal hearing, for the purpose of the instant stipulation only, admits to the truth and accuracy of each and every one of the charges in accusation number D-3980. Respondent admits, for the purposes of the instant stipulation only, the following statements of fact and conclusions of law. On July 1, 1988 he undertook the medical care and treatment of patient Leticia E., a twenty-two year old female, gravida 4, para 1, sab 2, and tab 1, who was seen by respondent because of spotting per vaginam. The patient's last menstrual period was April 24, 1988, so that she was 9 weeks plus pregnant by date. Upon examination, the patient had a closed cervix with minimal brownish spotting. Respondent inserted a laminaria and advised the patient to return later that day. When Leticia E. returned, respondent gave her analgesia by injection, and respondent attempted an abortive curettage. The patient was experiencing too much pain, so respondent stopped the procedure, knowing that the curettage was incomplete. Respondent's care and treatment of Leticia E. constituted gross

negligence in that he sent her home, knowing that he had performed an incomplete dilatation and curettage, and grossly negligent in that he failed to immediately hospitalize her or send her to an emergency room.

8. The Board of Medical Quality Assurance has the authority to take disciplinary action against respondent's physician's and surgeon's certificate pursuant to Business and Professions Code sections 2220, 2227, and 2234.

9. Based on all the foregoing admissions, stipulations, and recitals, it is stipulated and agreed that the Board of Medical Quality Assurance may issue a decision upon this stipulation whereby:

A. Physician's and surgeon's certificate number C22630, heretofore issued to respondent, Lawrence L. Mc Alpine, M.D., is hereby revoked; provided, however, said revocation is stayed, and respondent is placed on probation for a period of five (5) years, on the following conditions:

1) During the period of probation, respondent shall be prohibited from supervising a Physician's Assistant;

2) Beginning the effective date of this Decision, and continuing for one hundred and twenty (120) days thereafter, respondent is suspended from practicing as a physician and surgeon. The period of suspension shall not run during any time that respondent is outside the State of California. If, during the period

of suspension, respondent leaves the State of California, respondent is required to immediately notify the Division in writing of the date of departure, and to immediately notify the Division, in writing, of the date of return.

3) Within sixty (60) days of the effective date of this Decision, respondent shall take and pass an oral or written examination administered by the Division or its designee. If respondent fails this examination, respondent must take and pass a re-examination consisting of a written as well as an oral examination. The waiting period between repeat examinations shall be at three month intervals until success is achieved. The Division shall pay the cost of the first examination, and respondent shall pay the cost of any subsequent re-examinations.

If respondent fails the first examination, respondent shall cease the practice of medicine until the re-examination has been successfully passed, as evidenced by written notice to respondent from the Division. Failure to pass the required examination no later than 100 days prior to the termination date of probation shall constitute a violation of probation.

4) Within ninety (90) days of the effective date of this Decision, respondent shall submit to the Division of Medical Quality, Board of Medical Quality

Assurance, for the Division's prior approval, an intensive clinical training program. The exact number of hours and specific content of the program shall be determined by the Division or its designee. Respondent shall successfully complete the training program and may be required to pass an examination administered by the Division or its designee related to the program's contents.

5) Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California.

6) Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the compliance with all the conditions of probation.

7) Respondent shall comply with the Division's probation surveillance program.

8) Respondent shall appear in person for interviews with the Division's medical consultant, upon request, at various intervals and with reasonable notice.

9) Neither the period of probation shall not run during the time that respondent is residing or practicing outside the State of California. If, during probation, respondent moves outside the State of California to reside or practice elsewhere, respondent is required to immediately notify the Division in

writing of the date of departure, and the date of return, if any.

B. Upon successful completion of probation, respondent's certificate will be fully restored.

C. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. The within stipulation shall be subject to the approval of the Division of Medical Quality, Board of Medical Quality Assurance. If the Division of Medical Quality, Board of

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Medical Quality Assurance fails to approve this stipulation, it shall be of no force or effect for either party.

JOHN K. VAN DE KAMP, Attorney General
of the State of California
LINDA J. VOGEL,
Deputy Attorney General

DATED: 11/14/89

LINDA J. VOGEL
Deputy Attorney General

Attorneys for Complainant

JOSEPH D. O'NEILL, Attorney-at-Law

DATED: 11-6-89

JOSEPH D. O'NEILL, Attorney-at-Law

Attorney for Respondent

I have read and understood the above document and have fully discussed it with my counsel. I agree to the above stipulation for settlement.

DATED: 11-6-89

LAWRENCE L. MC ALPINE, M.D.

Respondent

JOHN K. VAN DE KAMP, Attorney General
of the State of California
LINDA J. VOGEL,
Deputy Attorney General
3580 Wilshire Boulevard, Suite 800
Los Angeles, California 90010
Telephone: (213) 736-3512

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LAWRENCE L. MC ALPINE, M. D. 650 HOBSON WAY OXNARD, CALIFORNIA 93030 Physician's and Surgeon's Certificate No. C22630 Respondent.	NO. D-3980 ACCUSATION

Complainant, Kenneth Wagstaff, alleges as follows:

1. He is the Executive Director of the Board of Medical Quality Assurance of the State of California (hereinafter "the Board") and makes and files this accusation in his official capacity.

2. On or about January 31, 1961, Lawrence L. Mc Alpine, M.D. (hereinafter "respondent") was issued Physician's and Surgeon's Certificate Number C22630 to practice medicine in the State of California. On December 31, 1980, an Accusation was filed against respondent's physician's and surgeon's certificate.

A true and correct copy of that Accusation is appended hereto as Exhibit "A" and is hereby incorporated by reference as though fully set forth at this point. On April 30, 1981 a Supplemental Accusation was filed against respondent's physician's and surgeon's certificate. A true and correct copy of that Supplemental Accusation is appended hereto as Exhibit "B" and is hereby incorporated by reference as though fully set forth at this point. On August 16, 1982 a Decision became effective which revoked respondent's physician's and surgeon's certificate, but stayed the revocation and placed the respondent on five years probation under certain terms and conditions. A true and correct copy of that Decision is appended hereto as Exhibit "C", and is hereby incorporated by reference as though fully set forth at this point. Respondent's probation terminated on August 16, 1987. At all times relevant to the acts and omissions charged in the instant accusation, respondent's physician's and surgeon's certificate was in full force and effect.

3. Business and Professions Code sections 2003 and 2004 provide, in pertinent part, that there is a Division of Medical Quality within the Board of Medical Quality Assurance, responsible for the enforcement of the disciplinary provisions of the Medical Practice Act (Chapter 5 of Division 2 of the Business and Professions Code); the administration and hearing of disciplinary actions appropriate to findings made before a medical quality review committee, the division, or an administrative law judge; and the suspension, revocation, or the

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imposition of limitations on certificates after the conclusion of disciplinary action.

4. Business and Professions Code sections 2220, 2227, and 2234 authorize the Division of Medical Quality to suspend or revoke a physician's and surgeon's certificate or to take other disciplinary action against a certificate holder who is guilty of unprofessional conduct.

5. Business and Professions Code section 2234, subdivision (b) provides that gross negligence is unprofessional conduct.

6. Respondent's certificate as a physician and surgeon is subject to discipline for violation of Business and Professions Code section 2234, subdivision (b), in that he committed acts of gross negligence, as more particularly alleged as follows:

A. On or about July 1, 1988, respondent undertook the medical care and treatment of patient Leticia E., a twenty-two year old female Gravida 4, Para 1, SAB 2, and TAB 1, who was seen by respondent on July 1, 1988 because of spotting per vaginam. The patient's last reported menstrual period was April 24, 1988, so that she was 9 plus weeks pregnant by dates.

1. Upon examination, the patient had a closed cervix with minimal brownish spotting.

2. Respondent inserted a laminaria and advised the patient to return the next day.

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3. On July 2, 1988 respondent gave the patient analgesia by injection and attempted an abortive curettage. The patient was experiencing too much pain, so respondent stopped the procedure, knowing that the curettage was incomplete.

4. Respondent gave the patient antibiotics, and advised her to return to his office the next day.

B. Respondent's care and treatment constituted gross negligence in that:

1. Respondent sent the patient home knowing he had performed an incomplete dilation and curettage.

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2. Respondent failed to immediately hospitalize the patient or refer her to an emergency room.

WHEREFORE, complainant prays that the Division hold a hearing on the matters alleged herein, and following that hearing issue a decision:

1. Revoking or suspending certificate number C22630, heretofore issued to respondent;

2. In the event that discipline less than complete revocation of respondent's physician and surgeon's certificate be imposed, prohibiting respondent from supervising a physician's assistant;

3. Taking such other action as it deems proper.

DATED: June 8, 1989

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

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5-7272

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of the State of California
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Telephone: (213) 736-3512

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. D-3980
LAWRENCE L. MCALPINE, M.D. 650 HOBSON WAY OXNARD, CALIFORNIA 93030 Physician'S and Surgeon'S Certificate Number C22630 Respondent.	NOTICE OF AMENDMENT

TO THE RESPONDENT ABOVE-NAMED AND HIS ATTORNEY:

PLEASE TAKE NOTICE that complainant Kenneth Wagstaff, by and through his attorney, John K. Van De Kamp, Attorney General, by Linda J. Vogel, Deputy Attorney General, hereby amends the Accusation heretofore filed herein as follows:

1) In subparagraph 6 A 2 (page 3, lines 25 and 26) the following is stricken in line 26: "the next day", and the following is inserted in its place: "later that day," so that subparagraph 6 A 2 reads as follows:

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2. "Respondent inserted a laminaria and advised the patient to return later that day."

2) In subparagraph 6 A 3 (page 4, line 1 through 5), the following is stricken in line 1: "July 2, 1988", and the following is inserted in its place: "July 1, 1988," so that subparagraph 6 A 3 reads as follows:

3. "On July 1, 1988 respondent gave the patient analgesia by injection and attempted an abortive curettage. The patient was experiencing too much pain, so respondent stopped the procedure, knowing that the curettage was incomplete."

DATED: This 1st day of November 1989.

JOHN K. VAN DE KAMP, Attorney General
LINDA J. VOGEL
Deputy Attorney General

Linda J. Vogel/s.m.

LINDA J. VOGEL
Deputy Attorney General

Attorneys for Complainant

EXHIBIT A

GEORGE DEUKMEJIAN, Attorney General
ANTONIO J. MERINO
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3580 Wilshire Boulevard
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(213) 736-2009 or 736-2034

Attorneys for Complainant

STATE OF CA...
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Assurance
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4/7/89

DEPUTY CHIEF ENFORCEMENT

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. D-2650
LAWRENCE L. McALPINE, M.D. 989 Camino Del Retiro Santa Barbara, CA 93110	ACCUSATION
Physician's and Surgeon's Certificate No. C-22630,	
Respondent.	

Complainant, Robert G. Rowland, alleges that:

1. He is the executive director of the Board of Medical Quality Assurance (hereinafter the "board"), and makes and brings this accusation solely in his official capacity.

2. In or about 1961, respondent Lawrence L. McAlpine, M.D. (hereinafter "respondent"), was issued physician's and surgeon's certificate number C-22630 by the board. Said certificate is now, and was at all times mentioned herein, in full force and effect.

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3. Pursuant to the provisions of sections 2360 and 2361 of the Business and Professions Code (hereinafter the "code"), the Division of Medical Quality of the board may discipline any holder of a certificate who is guilty of unprofessional conduct.

4. Section 2361, subdivision (c) of the code, provides that repeated similar negligent acts constitute unprofessional conduct for a physician and surgeon.

5. Section 2361, subdivision (d) of the code, provides that incompetence constitutes unprofessional conduct for a physician and surgeon.

6. Respondent is subject to disciplinary action pursuant to section 2361, subdivision (d) of the code, in that he has been incompetent in discharging his duties as a physician as follows:

A. On or about January 6, 1976, Elizabeth K. was admitted to Oxnard Community Hospital upon onset of spontaneous labor. Respondent was Ms. K's attending physician. Ms. K. had been under the care of respondent. Prior to admission Ms. K. had informed respondent about her prior pregnancies which included two births. She had also informed respondent that both infants had required exchange transfusions, and that one infant had died. Respondent failed to complete sections of the hospital records on previous pregnancies and Rh antibody titer and status.

B. On or about January 7, 1976, Ms. K. gave birth to a premature 4-lb. 9½ oz. male infant. During this

first day the blood type of mother and infant were obtained. Ms. K's blood type is O Rh positive and the infant's is B positive. On respondent's orders, Coomb's testing and antibody screening to determine blood incompatibility were performed on the umbilical cord blood. The results were a negative direct Coombs and antibody screening positive for hr-c antibody, indicating blood incompatability. Bilirubin level was a total of 2.6 mg. T.

C. On or about January 9, 1976, 48 hours after birth, the bilirubin test was repeated and a total level of 23.3 mg. T. obtained. Three days after birth, respondent placed the infant under bilights in response to rapidly developing jaundice. On or about January 10, 1976, bilirubin level was a total of 27.5. mg. T.

D. On or about January 10, 1976, respondent transferred the infant to the Intensive Care Nursery at General Hospital of Ventura County (hereinafter "Ventura General"). The infant was admitted to Ventura General and diagnosed as suffering from both ABO incompatability and hr-c incompatibility and hyperbilirubinemia.

E. At Ventura General, the infant, under the care of other physicians was given two exchange transfusions to control hyperbilirubinemia. On or about January 16, 1976, the infant was discharged with a low bilirubin and followed as an outpatient.

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F. Respondent was incompetent in that he failed to monitor the infant's condition at sufficiently frequent intervals following birth, despite his knowledge of Ms. R's obstetric history; and in failing to render appropriate therapy upon identification of an antibody in the infant's serum even after a dangerously high bilirubin level was obtained at 48 hours of age.

G. Respondent was further incompetent in providing inappropriate therapy and in delaying the transfer of the infant to a facility where definitive treatment could be obtained.

7. Respondent is further subject to disciplinary action pursuant to section 2361, subdivision (d) of the code, in that he has been incompetent in discharging his duties as follows:

A. During October or November of 1978, Rafaela R. began prenatal care visits to respondent. Respondent followed Ms. R's pregnancy from the fourth month. Ms. R. provided respondent with her medical history, including that her blood type was Rh negative, and she had previously given birth to two children.

B. On or about April 8, 1979, Ms. R's third child, a son was delivered at full term at Oxnard Community Hospital by Dr. T. Ozawa, M.D., who substituted for respondent at Oxnard Community Hospital. Testing of the umbilical cord blood revealed a positive direct Coomb's test. The infant's blood type was tested and classified as O Rh positive.

C. On or about April 9, 1979, respondent discharged Ms. R. and the infant without any instructions for care or treatment of jaundice. On or about April 13, 1979, five days after delivery, the infant was seen by another physician who noted the infant was suffering from severe neonatal jaundice. The infant was admitted to Ventura General where the diagnosis of Rh erythroblastosis was confirmed and total bilirubin was 30 mg. T.

D. The infant was treated at Ventura General with albumin infusion, followed by an exchange transfusion and subsequent phototherapy. The infant was discharged on or about April 16, 1979.

E. Respondent was incompetent in that he discharged the infant a day and a half after birth. The premature discharge prevented appropriate management of the infant's condition which respondent should have recognized when the mother's blood type was identified as Rh negative, when a Coomb's test administered at birth was positive, and when the bilirubin was noted as elevated at birth.

8. Respondent is subject to disciplinary action pursuant to section 2361, subdivision (c) of the code, in that his conduct, as set forth hereinabove at paragraphs 6 and 7, constitutes repeated similar negligent acts.

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WHEREFORE, complainant prays that the Division of Medical Quality hold a hearing on the matters alleged herein and following said hearing, issue a decision:

1. Taking such action as provided in sections 2372 and 2372.5 of the code; and

2. Taking such other and further action as it deems proper.

DATED: December 31, 1980.

Robert G. Rowland by AJM
ROBERT G. ROWLAND
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

AJM:HDW:eyg
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EXHIBIT B

GEORGE DEUKMEJIAN, Attorney General
ANTONIO J. MERINO,
HOLLY D. WILKENS,
Deputy Attorneys General
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Los Angeles, California 90010
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Attorneys for Complainant

STATE OF CALIFORNIA
Board of Medical Quality Assurance

Donald J. Krause 4/7/89
DEPUTY CHIEF-ENFORCEMENT

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LAWRENCE L. MCALPINE, M.D. 989 Camino Del Retiro Santa Barbara, CA 93110 Physician and Surgeon's Certificate No. C-22630, Respondent.	No. D-2650 FIRST SUPPLEMENTAL ACCUSATION

Complainant Robert Rowland is the executive director of the Board of Medical Quality Assurance (hereinafter the "board") and in addition to the matters contained in the accusation heretofore filed herein, and as cause for disciplinary action, alleges as follows:

9. Section 2234, subdivision (b), of the Business and Professions Code (hereinafter the "code"), formerly set forth in section 2361, subdivision (b), of the code, provides that gross negligence constitutes unprofessional conduct.

10. Respondent is further subject to disciplinary action pursuant to section 2234, subdivision (b), of the code, in that he has been grossly negligent in the treatment of a patient, as more particularly alleged as follows:

A. Complainant incorporates paragraph 6, subparagraph A through E, of the accusation at this point.

B. Respondent was grossly negligent in his treatment of Elizabeth K. in that notwithstanding the patient's medical history of two prior pregnancies and deliveries, respondent nevertheless failed to order antibody screening. Respondent was also grossly negligent in that he failed to order further blood testing of Ms. K. until the time of delivery and in that, respondent examined Ms. K. only three times before delivery.

C. Respondent was further grossly negligent in that he failed to monitor the infant's condition at sufficiently frequent intervals following birth, despite his knowledge of Ms. K's obstetric history; and in failing to render appropriate therapy upon identification of an antibody in the infant's serum even after a dangerously high bilirubin level was obtained at 48 hours of age. Respondent was also grossly negligent in providing inappropriate therapy and in delaying the transfer of the infant to a facility where definitive treatment could be obtained.

11. Respondent is further subject to disciplinary action pursuant to section 2234, subdivision (b) of the code, in that he has been grossly negligent in the treatment of a

patient, as more particularly alleged as follows:

A. Complainant incorporates paragraph 7, subparagraphs A through E, of the accusation at this point.

B. Respondent ran an antibody screen on Rafaela R. on her initial visit to respondent. The antibody screen was positive and the titer remained unchanged at six and one half months. Respondent did not make a record of identification of the antibody or of informing the patient of positive antibody screen and its significance.

C. Respondent was grossly negligent in his treatment of Rafaela R. in failing to make a record of identification of the antibody in light of initial positive antibody screen and the lack of change in titer. Respondent was also grossly negligent in failing to inform the patient of the positive antibody screen and lack of change in titer.

D. Respondent was further grossly negligent in discharging Ms. R.'s infant to home care without alerting Ms. R. to the potential danger to the infant from jaundice. Respondent was also grossly negligent in failing to refer the infant to Ventura General until bilirubin had reached dangerous levels.

WHEREFORE, complainant prays that the board hold a hearing on the matters alleged herein and following said hearing issue a decision:

1. Taking such action as provided in sections 2227, 2228, and 2229 of the code.

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2. Taking such other and further action as it deems proper.

DATED: April 30, 1981.

Robert G. Rowland
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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DEPUTY CHIEF-ENFORCEMENT

In the Matter of the Accusation Against: LAWRENCE L. McALPINE, M.D. 989 Camino Del Retiro Santa Barbara, CA 93110 Physician's and Surgeon's Certificate No. C-22630. Respondent.	Case No. D-2650 L-23313

DECISION

The attached Proposed Decision of the Medical Quality Review Committee was originally non-adopted by the Division of Medical Quality. The Division then proceeded to decide the case itself upon the record, including the transcript. The parties were afforded the opportunity to present both oral and written argument before the Division. During this process, respondent has offered to waive judicial review if probation conditions No. 7 and No. 8 were revised (as submitted) to satisfy concerns for safeguard to patient care. The Division considered the revisions to be reasonable and appropriate under the circumstances.

Therefore, having reviewed the case, the Division now makes this decision:

Except for the penalty order which shall be rewritten in its entirety below for convenience, the Division adopts and incorporates by reference the attached Proposed Decision of the Medical Quality Review Committee as its decision in the case.

The new penalty order in its entirety is as follows:

ORDER

Certificate No. C-22630 issued to respondent Lawrence L. McAlpine, M.D. is revoked.

However, revocation is stayed and respondent is placed on probation for five years upon the following terms and conditions:

1. Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine in California.

2. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

2. Respondent shall comply with the Board's probation surveillance program.

4. Respondent shall appear in person for interviews with the Board's medical consultant upon request at various intervals and with reasonable notice.

5. In the event respondent should leave California to reside or to practice outside the State, respondent must notify the Board in writing of the dates of departure and return. Periods of residency or practice outside California will not apply to the reduction of this probationary period.

6. Within 60 days of the effective date of this decision, respondent shall take and pass an oral clinical obstetrics and neonatal care examination to be administered by the Board or its designee. If respondent fails this examination, respondent must wait three months between re-examinations, except that after three failures respondent must wait one year to take each necessary re-examination thereafter. The Board shall pay the cost of the first examination, and respondent shall pay the costs of any subsequent examinations. If respondent fails to take and pass this examination by the end of the first year of probation, respondent shall cease the practice of medicine until this examination has been successfully passed and respondent has been so notified by the Board in writing.

7. (Revised) Respondent shall refer to a Board certified obstetrician or family practitioner for further care and treatment all obstetrical patients who have a history of blood incapatabilities or jaundiced infants, or who exhibit a significant positive antibody screen during pregnancy.

8. (Revised) Respondent shall refer to a Board certified pediatrician or family practitioner for further care and treatment all neonates whose mother falls into the description above or who develops jaundice within the first two weeks of life.

9. If an accusation or petition to revoke probation is filed against respondent during probation the Board of Medical Quality Assurance shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

Upon full compliance with the terms and conditions herein set forth and upon the expiration of the probationary period, the certificate shall be restored to its full privileges; provided, however, that in the event respondent violates or fails to comply with any of the terms and conditions hereof, the Board of Medical Quality Assurance, after notice to respondent and opportunity to be heard, may terminate this probation and reinstate the revocation or make such other order modifying the terms and probation herein as it deems just and reasonable in its discretion.

The effective date of this Decision shall be August 16, 1982.

SO ORDERED July 16, 1982

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

By: 

MILLER MEDEARIS
Secretary-Treasurer

EXHIBIT C

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LAWRENCE L. McALPINE, M.D. Certificate No. C-22630, Respondent.	NO. D-2650 L-23313 NOTICE OF NON-ADOPTION OF PROPOSED DECISION

Gerald F. Evans 4/7/69
DEPUTY CHIEF-ENFORCEMENT

TO ALL PARTIES:

YOU ARE HEREBY NOTIFIED that the Division of Medical Quality did not adopt the proposed decision in this case. The Division will now decide the case itself upon the record, including the transcript.

You are now afforded the opportunity to present both oral and written argument to the Division. If you want to make oral argument, you must file with the Division within 20 days from the date of this notice your written request for oral argument. Otherwise, this option shall be deemed waived. If any written request is timely received, all parties will then be notified in writing of the date, time and place for hearing oral arguments from both sides.

As to written argument, you will be notified in writing of the deadline date to file your written argument with the Division. Your right to argue on any matter is not limited, but the Division would be interested in persuasive discussions on the following matters:

> Why the license should not be revoked, or at the least, why there should not be an actual period of suspension with an additional order prohibiting obstetrical and neonatal practice during probation.

For its own use, the Division has ordered the preparation of the hearing transcript and records. At your own expense, you may order a copy of the same by personally contacting the transcript clerk at the Office of Administrative Hearings at: 314 West First Street, Los Angeles, CA 90012.

Please remember to include your proof of service that the opposing attorney was served with a copy of your written argument to the Division. The address for mailing or serving your request for oral argument and your written argument to the Division is as follows:

Division of Medical Quality
1430 Howe Avenue
Sacramento, CA 95825

DATED: January 29, 1982

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

Vernon A. Leeper
VERNON A. LEEPER, Program Manager
Enforcement Unit

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LAWRENCE L. McALPINE, M.D. 989 Camino Del Retiro Santa Barbara, CA 93110 Physician's and Surgeon's Certificate No. C-22630, Respondent.	CASE NO. D-2650 L-23313

PROPOSED DECISION

This matter came on regularly for hearing before a Panel of District 10 Medical Quality Review Committee, at Ventura, California, on October 13, 1981, at 10:00 a.m., and thereafter on October 14, 15, and 16, 1981, Richard J. Lopez, Administrative Law Judge of the Office of Administrative Hearings presiding. Panel members present were:

Barry Coughlin, M.D., Chairperson
Rebecca Argo, M.D.
T. Alan Hawley, D.C.

Antonio J. Merino and Holly D. Wilkens, Deputys Attorney General, represented the complainant. Respondent appeared in person and was represented by John S. Poucher, Attorney at Law.

At the outset of the hearing, on complainant's motion, the pleadings were amended as follows: at page 5, line 19 of the Accusation, the word "and" was inserted between the words "negative" and "when"; at page 5, line 20 of the Accusation, the comma was deleted and a period inserted in lieu thereof, and the remainder of the sentence at lines 20 and 21 of said page was stricken; the full sentence at page 3, lines 19-21 of the First Supplemental Accusation was stricken. Thereafter documentary and oral evidence, and evidence by way of stipulation and official notice was received, the matter was argued and submitted, and the members of the Panel proceeded to consider the matter. The Administrative Law Judge was present during the Panel's

onsideration of the case. The Panel duly considered the evidence in executive sessions on October 16, 17, and 20, 1981. The Panel now finds the following facts:

I

A. Robert G. Rowland, the Executive Director of the Board of Medical Quality Assurance (hereinafter the "Board"), made the Accusation and First Supplemental Accusation solely in his official capacity.

B. In 1961, respondent Lawrence L. McAlpine, M.D. (hereinafter "respondent"), was issued physician's and surgeon's certificate number C-22630 by the Board. Said certificate is now, and was at all times mentioned herein, in full force and effect.

II

During October or November of 1978, Rafaela R. began prenatal care visits to respondent. Respondent followed Ms. R.'s pregnancy from the fourth month. It was not established that Ms. R. provided respondent with her correct medical history, including that her blood type was Rh negative. She had previously given birth to two children.

On April 8, 1979, Ms. R.'s third child, a son, was delivered at full term at Oxnard Community Hospital by Dr. T. Ozawa, M.D., who substituted for respondent at Oxnard Community Hospital. On April 9, 1979, testing of the umbilical cord blood revealed a positive direct Coomb's test. The infant's blood type was tested and classified as O Rh positive.

On April 9, 1979, respondent discharged Ms. R. and the infant. It was not established that there were no instructions for care or treatment of jaundice. On April 13, 1979, five days after delivery, the infant was seen by another physician who noted the infant was suffering from severe neonatal jaundice. The infant was admitted to Ventura General where the diagnosis of Rh erythroblastosis was confirmed and total bilirubin was 30 mg. T.

The infant was treated at Ventura General with albumin infusion, followed by an exchange transfusion and subsequent phototherapy. The infant was discharged on April 16, 1979.

Respondent discharged the infant a day and a half after birth. The premature discharge prevented appropriate management of the infant's condition which respondent should have recognized when the mother's blood type was identified as Rh negative and when a Coomb's test administered at birth was positive. Respondent, reasonably, relied on another physician's reporting that the Coomb's test was negative.

III

Respondent's conduct, set forth in Finding II, does not constitute incompetence.

IV

Respondent ran an antibody screen on Ms. R. on her initial visit to respondent. The antibody screen was positive and the titer remained unchanged at six and one half months. Respondent did not make a record of identification of the antibody or of informing the patient of positive antibody screen and its significance.

It was not established that respondent failed to inform the patient of the positive antibody screen and the lack of change in titer. It was not established that respondent discharged Ms. R.'s infant to home care without alerting Ms. R. to the potential danger to the infant from jaundice.

V

It was established that infant R. was jaundiced at time of discharge from Oxnard Community Hospital; that the mother, Ms. R., was known to have Rh negative blood; that her titer was elevated during pregnancy; and that infant R. was discharged from the hospital prior to any hemoglobin or bilirubin tests being ordered or obtained.

VI

Respondent's conduct, set forth in Findings II, IV and V, did not constitute gross negligence.

VII

Respondent's conduct, set forth in Findings II, IV and V, does constitute negligence.

VIII

On January 6, 1976, Elizabeth K. was admitted to Oxnard Community Hospital. Respondent was Ms. K.'s attending physician. It was not established that Ms. K. had been under on-going care of respondent. Prior to admission Ms. K. had informed respondent about her prior pregnancies which included at least three births. It was not established that she had also informed respondent that the infants had required exchange transfusions. It was established that she informed respondent that three infants had died of jaundice. Respondent failed to complete sections of the hospital records on previous pregnancies and Rh antibody titer and status.

On January 7, 1976, Ms. K. gave birth to a premature 4-lb. 9½ oz. male infant. During this first day the blood type of mother and infant were obtained. Ms. K.'s blood type is O Rh positive and the infant's is B positive. On respondent's orders, Coomb's testing and antibody screening to determine blood incompatibility were performed on the umbilical cord blood. The results were a negative direct Coombs and antibody screening positive for hr-c antibody, indicating blood incompatibility. Bilirubin level was a total of 2.6 mg. T.

On January 9, 1976, 48 hours after birth, the bilirubin test was repeated and a total level of 23.3 mg. T. obtained. Two days after birth, another physician placed the infant under bililights in response to rapidly developing jaundice. On January 10, 1976, bilirubin level was a total of 27.5 mg. T.

On January 10, 1976, respondent transferred the infant to the Intensive Care Nursery at General Hospital of Ventura County (hereinafter "Ventura General"). The infant was admitted to Ventura General and diagnosed as suffering from both ABO incompatibility and hr-c incompatibility and hyperbilirubinemia.

At Ventura General, the infant, under the care of other physicians was given two exchange transfusions to control hyperbilirubinemia. On or about January 16, 1976, the infant was discharged with a low bilirubin and followed as an outpatient.

Respondent failed to monitor the infant's condition at sufficiently frequent intervals following birth, despite his knowledge of Ms. K.'s obstetric history; and failed to render appropriate therapy upon identification of an antibody in the infant's serum even after a dangerously high bilirubin level was obtained at 48 hours of age.

Respondent provided inappropriate therapy and delayed the transfer of the infant to a facility where definitive treatment could be obtained.

IX

Respondent's conduct, set forth in Finding VIII, did not constitute incompetence.

X

Respondent failed to order antibody screening on Elizabeth K. notwithstanding the patient's medical history of prior pregnancies and deliveries with three infant deaths from jaundice. It was not established that respondent examined Ms. K. more than once before delivery.

Respondent failed to monitor the infant's condition at sufficiently frequent intervals following birth, despite his knowledge of Ms. K.'s obstetric history; and failed to render appropriate therapy upon identification of an antibody in the infant's serum even after a dangerously high bilirubin level was obtained at 48 hours of age. Respondent provided inappropriate therapy and delayed the transfer of the infant to a facility where definitive treatment could be obtained.

XI

It was established that respondent was present at Oxnard Community Hospital on January 8, 1976; that he was aware of the incompatibility problem; that he failed to examine infant K. or order appropriate laboratory tests, thus delaying the initiation of appropriate therapy.

XII

Respondent's conduct, set forth in Findings VIII, X and XI, does not constitute gross negligence.

XIII

Respondent's conduct, set forth in Finding VIII, X and XI, does constitute negligence.

XIV

Respondent's conduct, set forth in Findings II, IV and V, and Findings VIII, X and XI, collectively, constituted repeated similar acts.

XV

Respondent is 48 years old and has been a physician for over 20 years. He is Board certified in clinical and anatomical pathology and in Family Practice. He practiced medicine in a walk-in type office in a socio-economically depressed area of Oxnard from 1973 to 1980. There has been no prior discipline of respondent's certificate.

XVI

The laboratory at Oxnard Community Hospital failed to provide timely reports, thus contributing to the delay in treatment in both matters.

XVII

Adequate support was not provided by the physicians responsible for the patients' care in the absence of respondent.

* * * * *

Pursuant to the foregoing findings of fact, the Panel makes the following determination of issues:

I

Cause exists for discipline of respondent's certificate pursuant to Business and Professions Code (hereinafter "Code") Sections 2360 and 2361 (now Section 2234) in that it was established that respondent violated the following section of that Code:

Section 2361(c) (now Section 2234(c)) by reason of Findings II, IV, V, VII, VIII, X, XI, XIII, and XIV, all collectively.

II

Cause does not exist for discipline of respondent's certificate pursuant to Business and Professions Code Sections 2360 and 2361 (now Section 2234) in that it was not established that respondent violated the following sections of that Code:

A. Section 2361 (d) (now Section 2234(d)) by reason of Findings II and III, collectively.

B. Section 2361(b) (now Section 2234(b))) by reason of Findings II, IV, V, and VI, collectively.

C. Section 2361(d) (now Section 2234(d)) by reason of Findings VIII and IX, Collectively.

D. Section 2361(b) (now Section 2234(b) by reason of Findings VIII, X, XI and XII, collectively.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The Physician's and Surgeon's Certificate No. C-22630 heretofore issued to respondent by the Board, is hereby revoked; provided, however, that execution of said order of revocation is hereby stayed for a period of five (5) years and respondent is placed on probation for said five (5) years upon the following terms and conditions:

1. Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine in California.

2. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

3. Respondent shall comply with the Board's probation surveillance program.

4. Respondent shall appear in person for interviews with the Board's medical consultant upon request at various intervals and with reasonable notice.

5. In the event respondent should leave California to reside or to practice outside the State, respondent must notify the Board in writing of the dates of departure and return. Periods of residency or practice outside California will not apply to the reduction of this probationary period.

6. Within 60 days of the effective date of this decision, respondent shall take and pass an oral clinical obstetrics and neonatal care examination to be administered by the Board or its designee. If respondent fails this examination, respondent must wait three months between re-examinations, except that after three failures respondent must wait one year to take each necessary re-examination thereafter. The Board shall pay the cost of the first examination, and respondent shall pay the costs of any subsequent examinations. If respondent fails to take and pass this examination by the end of the first year of probation, respondent shall cease the practice of medicine until this examination has been successfully passed and respondent has been so notified by the Board in writing.

7. Respondent shall obtain written consultation from a Board certificated obstetrician or family practitioner on all obstetrical patients who have a history of blood incompatibilities or jaundiced infants, or who exhibit positive antibody screen during pregnancy.

8. Respondent shall obtain written consultation from a Board certified pediatrician or family practitioner for all neonates whose mother falls into the description above or who develops jaundice within the first two weeks of life.

9. If an accusation or petition to revoke probation is filed against respondent during probation the Board of Medical Quality Assurance shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

Upon full compliance with the terms and conditions herein set forth and upon the expiration of the probationary period, the certificate shall be restored to its full privileges; provided, however, that in the event respondent violates or fails to comply with any of the terms and conditions hereof, the Board of Medical Quality Assurance, after notice to respondent and opportunity to be

heard, may terminate this probation and reinstate the revocation or make such other order modifying the terms and probation herein as it deems just and reasonable in its discretion.

I hereby submit the foregoing which constitutes the Proposed Decision of the Panel of District 10 Medical Quality Review Committee in the above-entitled matter as a result of the hearing held before said Panel at Ventura, California, on October 13, 14, 15, and 16, 1981, and recommend its adoption as the decision of the Division of Medical Quality Assurance.

DATED: 11/2/81

BARRY COUGHLIN, M.D.
Chairperson

RJL:ss